In general, one must avoid using such commonplace phrases as "you see, I told you so". Something gentler and more effective must be said to those who fail to follow sound medical guidance. Instead of "told you so", a "sorry, that you were unable to follow our medical advice" could have a much better effect. Most of us don't like to be scolded as if we were schoolchildren, especially when we have to face the deterioration of our own health. In order to really help the patient, the physician must not put herself in the role of a moral judge who simply implies that "you have been told, now you must bear the consequences". Yes, the patient has been told, but she may not have been told humanely or convincingly. Or, for hundreds of reasons, the patient may not have been able to change her lifestyle. For example, not every human being is equipped with omnipotent will power and not everybody is able to manage stressful situations perfectly well, or even well. It is easy to blame the patient for failing to achieving the therapeutic goal. The physician's objective, however, is to treat the patient and to promote his wellbeing, instead of finding out who, when, and how she was at fault.

Therefore, we believe that a real commitment to patients as well as to the art of medicine compels us to seldom give up on a patient and keep challenging non-compliance as if it were an integral part of our mission. In most cases our efforts will succeed, and as a result, not only our patients, but we too, will feel better. Granted, our salary will not be higher, nor will we necessarily be more highly valued for our moral integrity by others, but our self worth and professional pride may increase to a level where we find more fulfilment in our lives.

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LETTER

Neonatal outcomes and risk/benefit ratio of induced multiple pregnancies

During recent years we have seen and assisted at a significantly increased number of twin births. The main reason for this increase in the frequency of twin births is the increasing number of so called "induced pregnancies", whether through hormonal stimulation or artificial insemination techniques.

It is well known[1] that twins have high mortality and morbidity rates during the perinatal and the following period. The characteristics of conception and pregnancy can determine the development of several pathologies, including prematurity and intrauterine growth retardation, twin to twin transfusion, cardiorespiratory depression, and respiratory distress syndrome, all of which are very common.

Twin pregnancy represents therefore a biological risk factor and needs a very high level of obstetrical and neonatological management, achievable only in highly specialised and well equipped centres; a very high level of investment in terms of human and economic resources is also required.

A recent study carried out[2] by the Department of Neonatology at the A Gemelli hospital of the Catholic University of Rome shows a significantly higher incidence of prematurity, low birth weight, severe cardiorespiratory depression at birth, (Apgar 0–3) and respiratory pathology, among twins born from "induced pregnancies" than from those born from spontaneous pregnancies.

Such a high incidence of respiratory pathology and cardiorespiratory depression at birth does not seem to be related to prematurity. In fact mean gestational age and mean birth weight of the neonates with severe depression at birth and respiratory diseases are similar in induced and spontaneous pregnancy.

In multiple pregnancies such results are in agreement with the higher incidence of prematurity and low birthweight, already observed by other authors,[3–6] in single newborns from "induced pregnancies", in comparison to those from spontaneous pregnancies.

Quite apart from any clinical implications this situation leads us to consider the ethics of this situation.

Wider and multicentre studies will be necessary if we are to understand whether the induction of pregnancy is a strategy with an acceptable risk/benefit ratio, or whether the possible above mentioned complications can reduce the benefits for a couple of having children.

Also, it will probably be necessary to examine socioeconomic problems related to clinical and treatment needs for pregnancy or for newborn babies. In fact preterm babies often make large demands on the therapies in the neonatal intensive care unit, require long times of stay in hospital, and social support and rehabilitation after they leave the hospital.

This implies a remarkable use of technological, human, and economic resources in order to guarantee their survival and optimum quality of life.

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